		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040014

Facility Name: Manorcare at Skokie

Address: 4660 Old Orchard Road (Number) Skokie (City) 60076 (Zip Code)

County: Cook

Telephone Number: (847) 676-4800 **Fax #** (847) 676-4860

HFS ID Number: 520886946020

Date of Initial License for Current Owners: 11/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2004 to 05/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,457	1,140	2,886	5,483	8
9	SNF/PED					9
10	ICF	6,363			6,363	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,820	1,140	2,886	11,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.95%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 2,546

Medicare Intermediary CareFirst

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 5/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Skokie # 0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	176,493	10,960	4,920	192,373	1,133	193,506		193,506			1
2	Food Purchase		60,538		60,538		60,538	(573)	59,965			2
3	Housekeeping	70,116	3,284	74	73,474		73,474		73,474			3
4	Laundry	55,331	4,025	3,992	63,348		63,348		63,348			4
5	Heat and Other Utilities			79,450	79,450	2,613	82,063		82,063			5
6	Maintenance	35,428	4,081	75,300	114,809		114,809	(28,557)	86,252			6
7	Other (specify):* **Med Waste Utilities**			1,126	1,126		1,126		1,126			7
8	**TOTAL General Services**	337,368	82,888	164,862	585,118	3,746	588,864	(29,130)	559,734			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	834,223	58,013	17,337	909,573	19,317	928,890	(38)	928,852			10
10a	Therapy	139,281	1,789	120,356	261,426		261,426		261,426			10a
11	Activities	25,057	1,502	2,240	28,799		28,799		28,799			11
12	Social Services	40,083	93	1,901	42,077		42,077		42,077			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,038,644	61,397	159,834	1,259,875	19,317	1,279,192	(38)	1,279,154			16
	C. General Administration											
17	Administrative	62,857		151,678	214,535	(48,546)	165,989		165,989			17
18	Directors Fees											18
19	Professional Services			4,834	4,834		4,834	(4,834)				19
20	Dues, Fees, Subscriptions & Promotions			40,048	40,048		40,048	(7,803)	32,245			20
21	Clerical & General Office Expenses	180,690	24,911	69,041	274,642		274,642	(55,795)	218,847			21
22	Employee Benefits & Payroll Taxes			286,148	286,148	17,759	303,907		303,907			22
23	Inservice Training & Education			2,500	2,500		2,500		2,500			23
24	Travel and Seminar			4,287	4,287		4,287		4,287			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,951	55,951		55,951		55,951			26
27	Other (specify):*											27
28	**TOTAL General Administration**	243,547	24,911	614,487	882,945	(30,787)	852,158	(68,432)	783,726			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,619,559	169,196	939,183	2,727,938	(7,724)	2,720,214	(97,600)	2,622,614			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Skokie #0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			150,967	150,967	7,724	158,691		158,691			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			106,469	106,469		106,469	4,934	111,403			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			42,671	42,671		42,671		42,671			35
36	Other (specify):*											36
37	**TOTAL Ownership**			300,107	300,107	7,724	307,831	4,934	312,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			633	633		633	(633)				38
39	Ancillary Service Centers		83,085		83,085		83,085		83,085			39
40	Barber and Beauty Shops			2,387	2,387		2,387		2,387			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,660	30,660		30,660		30,660			42
43	Other (specify):* **See Attached Schedule**		15,383	2,698	18,081		18,081		18,081			43
44	**TOTAL Special Cost Centers**		98,468	36,378	134,846		134,846	(633)	134,213			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,619,559	267,664	1,275,668	3,162,891		3,162,891	(93,299)	3,069,592			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(573)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(54)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(633)	38		16
17	Non-Care Related Fees	(28,557)	6		17
18	Fines and Penalties	(1,500)	21		18
19	Entertainment				19
20	Contributions	(1,375)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,834)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,866)	21		24
25	Fund Raising, Advertising and Promotional	(7,803)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	4,934	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,299)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,299)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Skokie

ID# 0040014

Report Period Beginning: 06/01/2004

Ending: 05/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medical Transport Non-Amb.	$ (38)	10	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Skokie # 0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(573)	0	0	0	0	0	0	0	0	0	0	(573)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(28,557)	0	0	0	0	0	0	0	0	0	0	(28,557)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29,130)	0	0	0	0	0	0	0	0	0	0	(29,130)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(38)	0	0	0	0	0	0	0	0	0	0	(38)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(38)	0	0	0	0	0	0	0	0	0	0	(38)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,834)	0	0	0	0	0	0	0	0	0	0	(4,834)	19
20	Fees, Subscriptions & Promotions	(7,803)	0	0	0	0	0	0	0	0	0	0	(7,803)	20
21	Clerical & General Office Expenses	(55,795)	0	0	0	0	0	0	0	0	0	0	(55,795)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,432)	0	0	0	0	0	0	0	0	0	0	(68,432)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,600)	0	0	0	0	0	0	0	0	0	0	(97,600)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Skokie** **#** **0040014** **Report Period Beginning:** **06/01/2004** **Ending:** **05/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	4,934	0	0	0	0	0	0	0	0	0	0	4,934	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,934	0	0	0	0	0	0	0	0	0	0	4,934	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(633)	0	0	0	0	0	0	0	0	0	0	(633)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(633)	0	0	0	0	0	0	0	0	0	0	(633)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,299)	0	0	0	0	0	0	0	0	0	0	(93,299)	45

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, Ohio			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Cost	$ 151,678	HCR ManorCare, Inc.	100.00%	$ 151,678	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	11,290	Heartland Management Services	100.00%	11,290		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 162,968			$ 162,968	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 5/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: ((419) - 252-5500
Fax Number: ((419) - 252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.	$	$	3,071,335	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	1,043,233	571,891	3,071,335	1,133	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.	223,707		3,071,335	291	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	2,139,042		3,071,335	2,322	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.	12,987,607	8,226,246	3,071,335	16,872	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	2,252,260	1,199,059	3,071,335	2,445	6
7	17	General & Administrative - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.	16,611,639	15,056,893	3,071,335	21,580	7
8	17	General & Administrative - Poole	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	75,121,310	43,509,256	3,071,335	81,553	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.	3,924,545		3,071,335	5,098	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	11,662,215		3,071,335	12,661	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	357 Nurs. Fac.			3,071,335	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	357 Nurs. Fac.	7,114,804		3,071,335	7,724	12
13										13
14		Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 151,679	25

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Skokie **#** 0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	112,660	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	117,594	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,934	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	104,969	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	1,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	111,403	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	106,761	8
	2001	100,968	9
	2002	109,694	10
	2003	114,116	11
	2004	109,127	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040014

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) - 252-5740 FAX #: (419) - 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-103-024-0000	See Attached	$ 56,827.57	$ 56,827.57
2.	10-10-103-029-0000	See Attached	$ 230.25	$ 230.25
3.	10-10-103-024-0000	See Attached	$ 51,958.98	$ 51,958.98
4.	10-10-103-029-0000	See Attached	$ 110.02	$ 110.02
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,126.82	$ 109,126.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,033 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 300,000	1
2					2
3	TOTALS			$ 300,000	3

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	56			1994	$ 1,940,000	$ 48,500		$ 48,500	$	$ 544,007	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9						79,186		79,186		701,238	9
10	Doors/Windows			1995	1,331,819						10
11	Electrical			1996	7,023						11
12	Professional Services			1996	4,374						12
13	Medical Gas System			1996	8,622						13
14	Replace Water Pump Unit			1996	3,449						14
15	Doors/Hardware			1996	3,634						15
16	Carpeting			1996	4,847						16
17	Medical Gas System			1996	2,342						17
18	Professional Fees			1996	19,419						18
19	Wallcovering			1996	6,529						19
20	Plumbing			1996	25,335						20
21	Remodel OT			1996	60,000						21
22	Remodel Washrooms			1996	1,464						22
23	Electrical			1996	20,681						23
24	HVAC/Ductwork			1996	7,291						24
25	Wall Repairs			1996	4,891						25
26	Doors			1996	1,692						26
27	Landscaping			1996	1,812						27
28	Phone System			1997	1,762						28
29	Wallcoverings			1997	2,458						29
30	HVAC			1997	1,502						30
31	Carpeting			1997	21,340						31
32	Install CATV Jacks			1997	5,314						32
33	Remodel Offices			1997	5,548						33
34	HVAC			1997	22,516						34
35				1997	8,508						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Repair Walls	1997	1,328						38
39	Install New Siding	1997	20,000						39
40	Install Shower Tile	1997	15,817						40
41	Install Ball Valve	1997	1,955						41
42	Kitchen Plumbing	1997	7,446						42
43	Remodeling Tub/Shower	1997	9,300						43
44	Nurse Call Service	1997	1,795						44
45	Lighting	1997	13,266						45
46	Flooring	1997	6,671						46
47	New Siding/Soffit	1997	14,600						47
48	Office Remodeling	1998	6,000						48
49	Toilet Access	1998	1,612						49
50	Soors/Windows	1998	14,763						50
51	Electrical	1998	4,289						51
52	Carpeting	1998	3,457						52
53	Roofing	1998	1,915						53
54	HVAC	1998	11,786						54
55	Painting/Wallcoverings	1998	5,240						55
56	Painting/Wallcovering	1998	2,266						56
57	Developers	1998	5,555						57
58	HVAC	1998	797						58
59	Sign	1998	11,862						59
60	Comm. Edison	1998	2,842						60
61	Painting/Wallcovering	1999	62						61
62	Paving	1998	18,870						62
63	General construction	1999	6,241						63
64	Vinyl Wall Border	1999	191						64
65	Suite Signs	1999	942						65
66	Wallcoverings	1999	3,101						66
67	Wall Borders	1999	1,339						67
68	Vinyl Wallcoverings	1999	512						68
69	Freight	1999	117						69
70	TOTAL (lines 4 thru 69)		$ 3,720,109	$ 127,686		$ 127,686	$	$ 1,245,245	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,720,109	$ 127,686		$ 127,686	$	$ 1,245,245	1
2	Relaminate Nurse Station	1999	7,015						2
3	Carpet	1999	14,458						3
4	Mag Door Holders	1999	756						4
5	Carpeting	1999	557						5
6	Handrail	2000	5,480						6
7	Border	2000	650						7
8	Molding & Painting	2000	3,958						8
9	Freight Wallcovering	2000	117						9
10	Heating	2000	7,015						10
11	Heritage Corridors	2000	7,618						11
12	Door Frame Protection	2000	741						12
13	Door Hardware	2000	49						13
14	Solarium	2000	3,260						14
15	Vinal Wall Covering, Corner Guards, & Painting	2000	5,772						15
16	Carpet	2000	752						16
17	Freight Carpet	2000	68						17
18	Plumbing Public Restrooms	2000	989						18
19	Plumbing remaining balance	2000	989						19
20	Door Work/Heating	2000	832						20
21	Painting - Exterior Bldg	2000	3,690						21
22	Doors	2000	6,121						22
23	Exterior Renovation	2000	15,230						23
24	Concrete	2000	2,570						24
25	Carpeting & Sheet Vinyl	2000	28,655						25
26	Carpet - O/T Room	2000	3,239						26
27	Curbing	2002	3,760						27
28	Boulders	2002	1,000						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,845,451	$ 127,686		$ 127,686	$	$ 1,245,245	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,305,730	$ 23,281	$ 23,281	$		$ 1,263,095	71
72	Current Year Purchases	28,557						72
73	Fully Depreciated Assets							73
74				7,724	7,724			74
75	TOTALS	$ 1,334,287	$ 23,281	$ 31,005	$ 7,724		$ 1,263,095	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,479,738	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,691	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,724	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,508,340	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 42,671 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1934	hrs	$ 57,509	1,440	$ 35,993	$	3,374	$ 93,502	1
2	Licensed Speech and Language Development Therapist	10a	822	hrs	24,433	1,461	36,526	18	2,283	60,977	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	1928	hrs	57,339	1,684	42,121	5,698	3,612	105,158	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				83,085		83,085	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 139,281	4,585	$ 114,640	$ 88,801	9,269	$ 342,722	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at Skokie **#** 0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,091	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (44,691))	756,017		3
4	Supply Inventory (priced at)	14,480		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,014		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 780,602	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,000		13
14	Buildings, at Historical Cost	3,845,451		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,334,287		16
17	Accumulated Depreciation (book methods)	(2,508,340)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,971,398	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,752,000	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 19,315	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,033		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,138		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	31,247		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 303,733	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 303,733	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,448,267	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,752,000	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,044,430	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,044,430	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	913,473	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 913,473	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(509,636)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (509,636)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,448,267	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,123,892	1
2	Discounts and Allowances for all Levels	(493,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,630,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	518,228	6
7	Oxygen	15,851	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 534,079	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	565	12
13	Barber and Beauty Care	2,540	13
14	Non-Patient Meals	8	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,970	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 85,083	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,249,418	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	585,118	31
32	Health Care	1,259,875	32
33	General Administration	882,945	33
	B. Capital Expense		
34	Ownership	300,107	34
	C. Ancillary Expense		
35	Special Cost Centers	134,846	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,162,891	40
41	**Income before Income Taxes (line 30 minus line 40)****	(913,473)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (913,473)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,062	2,245	$ 72,311	$ 32.21	1
2	Assistant Director of Nursing	1,431	1,558	43,232	27.75	2
3	Registered Nurses	10,232	11,141	287,935	25.84	3
4	Licensed Practical Nurses	4,210	4,584	101,394	22.12	4
5	CNAs & Orderlies	25,568	27,839	315,877	11.35	5
6	CNA Trainees					6
7	Licensed Therapist	3,276	3,566	106,049	29.74	7
8	Rehab/Therapy Aides	1,235	1,344	33,232	24.73	8
9	Activity Director					9
10	Activity Assistants	2,020	2,197	25,057	11.41	10
11	Social Service Workers	1,918	2,010	40,083	19.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,439	14,498	176,493	12.17	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,047	35,428	17.31	17
18	Housekeepers	5,428	5,903	70,116	11.88	18
19	Laundry	4,716	5,149	55,331	10.75	19
20	Administrator	1,905	2,080	62,857	30.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,056	11,918	180,690	15.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,102	1,204	13,474	11.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,537	99,283	$ 1,619,559 *	$ 16.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,980	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,980		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Martinez	Administrator		$ 62,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,857

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 151,678
TOTAL (agree to Schedule V, line 17, col. 3)	$ 151,678
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, Mielke & Flowers	Legal	$ 4,834
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,834

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 10,079
Unemployment Compensation Insurance	25,489
FICA Taxes	114,403
Employee Health Insurance	119,424
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	3,134
401K	7,042
Other Employee Benefits	665
Tuit Pgrm	5,577
Emp Uniforms	335
P/R O/H	0
Home Office	17,759
TOTAL (agree to Schedule V, line 22, col.8)	$ 303,907

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,330
Advertising: Employee Recruitment	14,085
Health Care Worker Background Check	930
(Indicate # of checks performed 47)	
Dues/Subscriptions	576
Association Dues	2,864
Advertising & Mktg/Lect Admin	20,198
Public Relations	65
Less: Mktg./Lect.	(72)
Less: Lobbying Expense	(924)
Less: Public Relations Expense	(65)
Non-allowable advertising	(6,742)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,245

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,287
Includes travel expenses to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,287

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Skokie # 0040014 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Skokie # 0040014 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2,864**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **924**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,242** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **30,660**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(8)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.